Study of Community Treatment Facilities

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Executive Summary

Pursuant to Welfare and Institutions Code (W&I Code) 4094.2(h), the State Department of Mental Health (DMH) contracted with Patricia Jordan, LCSW, and Beverly Abbot for a study of Community Treatment Facilities (CTFs) for children and youth. The purpose of the study was to examine the fiscal and programmatic aspects of this new type of residential facility for seriously emotionally disturbed youth, and to make recommendations for future funding and program strategies to support their continued development and implementation. In order to accomplish this study, all available relevant background information, regulations, rules and policies were reviewed, site visits were made to all currently operating CTFs and more than 25 interviews were conducted with involved stakeholders, either in person or by telephone.

Just as in the legislative and regulatory design process, the development and ongoing operation of CTFs are a challenging collaboration. CTFs are serving the youth they were designed to serve and CTFs fill a gap in the system, providing services to the most troubled youth. Providing this level of care is costly. Total costs per child per day average about $630, excluding education costs. The major factors affecting costs are intensity of staffing and number of beds. The currently operating facilities span a continuum that on the one hand embodies an approach that is a step-down from acute/sub-acute facilities and on the other a step-up from a Rate Classification Level (RCL)14 group home. There is general agreement about the major issues facing these facilities in both fiscal and programmatic areas. There are issues of funding structure and costs, staffing, emergency interventions, medication policies, reporting and documentation, clients' legal status and rights, and provider risk and liability all of which are discussed in detail.

Department of Mental Health
Study of Community Treatment Facilities

Introduction

Pursuant to Welfare and Institutions Code (W&I Code), Section 4094.2(h), the State Department of Mental Health (DMH) contracted for a study of Community Treatment Facilities (CTFs) for youth who are seriously emotionally disturbed (SED). The purpose of the study was to examine the fiscal and programmatic aspects of this new type of residential facility for youth who are SED and to make recommendations for future funding and program strategies to support their continued development and implementation. This study looks at the funding structure, costs, regulations, policies and practices regarding CTFs as well as the clients served and services provided within the facilities that are currently in operation. Specific recommended actions with respect to future funding and program development are included at the end of the report.

Methodology

The following methods were utilized in conducting this study:

- Review of materials – All available documents pertaining to CTFs were reviewed, including legislation and regulations, original responses to the DMH Request for Applications (RFA), prior DMH reports, California Alliance for Children and Family Services (CACFS) documents, and fiscal and program documents from all of the currently operating facilities. Information from many of these documents is incorporated within this report.

- In-person and telephone interviews – All major categories of stakeholders were interviewed including:
    - DMH Systems of Care, Licensing and Certification and Program Compliance staff
    - California Department of Social Services (CDSS) Community Care Licensing Division (CCLD) and Rate-Setting staff
    - County Mental Health Department representatives from several counties, including counties with currently operating facilities
    - County Social Service and Probation Department representatives,
    - CTF providers and potential providers, including various staff from currently operating facilities, providers that are certified but not yet operating and providers who were approved, but have relinquished certification
    - California Mental Health Directors' Association (CMHDA) Children's System of Care Committee Chairperson
    - Members of the CMHDA CTF Committee
    - United Advocates for Children of California (UACC)
    - California Alliance of Child and Family Services (CACFS)
    - Parents
    - Youth
    - Protection and Advocacy, Inc.

- Facilities in Colorado and Texas where some California counties place youth with SED

- Site visits – Visits were made to all five currently operating facilities. With the exception of the visit to Starlight, they included meetings with administrative, program and fiscal staff, a review of program materials and client charts, a tour of each facility, meetings with parents and youth, and an opportunity to observe the programs in operation. The Starlight visit was combined with a CDSS/DMH monitoring visit in order to reduce duplication for the provider. At the facility charts were not reviewed and youth and parents were not individually interviewed although two parents participated in the site visit and told their story to the reviewers.

General Findings

- ***Just as in the legislative and regulatory design process, the development and ongoing operation of CTFs are a challenging collaboration***.

  The CTF model is the result of collaboration between DMH and CDSS. Funding, staffing requirements and regulations have been developed collaboratively. This approach is appropriate because the majority of the youth served in these facilities are served by both the mental health system and the social services system. The approach is consistent with the system of care philosophy that has driven children's mental health services in California for the last decade. The goal of the system of care model is to provide a comprehensive array of services planned and delivered in collaboration with the individuals and agencies that are involved in the lives of the children who are being served. These include the youth themselves, families, caregivers, schools, county departments of probation and social services, county mental health departments, public and private agencies and other organizations. Funding is braided and families and programs work in partnership to provide the highest quality and most cost effective services. The collaborative effort may be one of the most challenging components of implementing CTFs because of the number of stakeholders, multiple funding sources, legal issues involved in locked facilities and involuntary treatment, and the severity of the problems of the youth CTFs are intended to serve. The model was developed through a lengthy process that involved a broad array of concerned stakeholders including DMH and CDSS, local county mental health programs, other local county agencies, community-based private providers and families. The collaboration continues on both the state and local level around the operation of each facility. This kind of a partnership is not easy; the partners bring different perspectives, cultures, policies and procedures.

  Different funding sources have individualized rules, regulations and reporting requirements. Funding is accessed through CDSS and DMH at the state level, and county funds at the local level. Federal reimbursement is available through the use of both Title IV-E (the primary source for out-of-home placement funds for social service and probation youth) and Medi-Cal funding. All of the currently operating facilities have on-grounds non-public schools which are funded by their local education agencies.

The key to making the collaboration successful is to blend differences into a model that functions effectively and efficiently, encourages providers to create programs to serve youth with the most complex problems, supports programs in providing the highest quality services and produces successful outcomes for the youth that are served. All of this has not yet been fully achieved. The challenges and the strengths of this collaboration will be discussed in this study.

- ***CTFs are serving the youth they were designed to serve and CTFs fill a gap in the system, providing services to the most troubled youth.***

  The programs that are currently operating are serving youth with a high level of serious emotional and behavioral disorders who have not been served successfully in other programs, particularly other group homes. All of the information that was obtained through review of documents, interviews and site visits confirmed the fact that there is a need in the array of mental health services for this type of secure facility with intensive programming. These facilities are providing an alternative to state hospital and some out-of-state placements.

  County staff and facility staff reported the importance of the locked setting to engage youth in treatment. Each facility has a system by which youth earn privileges and greater degrees of freedom by demonstrating healthy behaviors and completing program tasks. As the youth make progress in the program, they earn "passes" which allow them the right to temporary supervised time outside the facility.

- ***The currently operating facilities span a continuum that on the one hand embodies an approach that is a step-down from acute facilities and on the other a step-up from a Rate Classification Level (RCL) 14 group home.***

  More discussion about these approaches will be included later in this report.

- ***There is general agreement about the major issues facing these facilities in both fiscal and programmatic areas***.

  The majority of issues which interfere with implementing and continued operation of CTFs involved funding structure and costs, staffing, emergency interventions, medication policies, reporting and documentation, clients' legal status and rights, and provider risk and liability. Fiscal issues not only present barriers to start-up of facilities; they also interfere with continuing program operations. All of these are discussed in detail in this report.

- ***Providing this level of care is costly.***

Available actual cost data from operational facilities include the initial start-up period and may not accurately reflect ongoing costs. Current operating expenses and revenues are included in this report. Based on CTF budgets submitted to DMH for Fiscal Year (FY) 2001/02, the costs per youth per day for CTFs average about $603.00 per day (excluding education costs) and vary significantly from facility to facility. The major factors driving costs are staffing and facility size. Smaller facilities and facilities

with higher ratios of child care staff cost more per child per month. The CTF cost per day compares to the total cost of the state hospital program of $611 per day.

Background Information

The concept of a CTF category of residential care has been under development since 1985 with the passage of Senate Bill (SB) 874 Chapter 1473, Statutes of 1985, Authored by Senator McCorquodale. With the development of systems of care and an emphasis on community-based services, mental health programs and residential care providers were looking for alternatives to state hospitals and for a way to provide and fund intensive mental health services within more home-like settings in the community. The CTF model sought to integrate intensive mental health treatment within existing residential group homes and institutions funded through the state foster care system. As state hospital beds decreased and the desire to have children remain in their communities increased, the child welfare system, the juvenile justice system and the education system were dealing with youth with higher levels of emotional and behavioral disorders. In 1988, additional amendments to the statutes by SB 240, Chapter 1271, Statutes 1987, Authored by Senator McCorquodale, added mental health oversight on the use of restraint, seclusion, and psychotropic medications for this new category of residential care. These amendments also clarified the roles of the CDSS and DMH. The CDSS role was to oversee the physical facilities and protect the health and safety of the residents. The DMH role was to oversee the treatment components, with particular attention to restraint and seclusion and medication issues. Throughout the next ten years, there were extensive deliberations about the nature of the treatment environment in this new type of facility, due process concerns, personal rights and treatment intervention protections, and appropriate levels of on-site supervision and staff training. In 1993, SB 282 (Chapter 1245, Statutes 1993, Authored by Senators Morgan and Russell), amended the CTF statutory language to allow a locked perimeter for these facilities, as many of these youth with serious problems could not be contained successfully in a less restrictive environment. The licensure requirements for CTFs currently require that they have the capacity to provide “secure containment." All of these discussions and decisions led to the current regulations issued in June of 1998. These included a statutory 400-bed limit on the number of CTFs to be implemented statewide. Working with CMHDA, the 400 beds were allocated on a regional basis as follows:

- Bay Area – 76 beds
- Central – 59 beds
- Superior – 20 beds
- Southern – 132 beds
- Los Angeles – 113 beds

In May of 1999, a Request For Applications (RFA) was issued by DMH. Regional stakeholder committees developed regional criteria in addition to DMH general criteria, reviewed the applications for their regions, and then forwarded their selections to DMH for certification. Fourteen providers were certified for a total of 400 beds in October of 1999 and were encouraged to apply to CDSS for a rate and licensure.

As a result of feedback from providers and potential providers, and to encourage CTF program implementation, Assembly Bill (AB) 2877, (Chapter 93, Statutes of 2000, Authored by Assembly Member Thomson), authorized CDSS to modify certain regulatory requirements for CTFs for FY 2001/02 and made other modifications to the program. Specific modifications included:

- Exemption from reporting the use of restraints unless the occurrence of restraint results in death, injury, unconsciousness or other medical condition

- The Community Care Licensing Division (CCLD) of CDSS was directed to issue alternative training and education requirements for CTF managers and staff, in consultation with DMH, patients' rights advocates, local mental health departments, county social service offices and care providers

- Licensing or certification deficiencies were to be forwarded and centrally reviewed by policy staff in the appropriate department before notice of any citation was issued to the facility

- CDSS/CCLD and the DMH Licensing and Certification Section were to conduct joint bi-monthly visits to licensed CTFs to monitor operations and provide technical assistance. Copies of DMH and CCLD reports are shared between departments.

AB 2877 provisions related to CTF licensing and certification were for one year only, with the provisions expiring on June 30, 2002. CDSS and DMH have agreed to extend these provisions. CDSS/CCLD will be implementing the extension by the waiver process pending regulatory change.

AB 2877 also authorized payment of a CTF supplemental rate of up to $2500 per child per month for FY 2001/02. This funding was designed to fill the gap between available funds and the funds necessary to meet the facility staffing and service requirements, while the state pursued long-term funding strategies. The supplemental rate was continued for FY 2002/03.

To date, five of the fourteen providers are operational:

- Seneca Center – Contra Costa County; accepted first clients September 2001
- Seneca Center – San Francisco County; accepted first clients March 2001
- Starlight Adolescent Center – Santa Clara County; accepted first clients October 2000.
- Starview – Los Angeles County; accepted first clients December 2001
- Vista Del Mar – Los Angeles County; accepted first clients May 2001

The two providers that were originally certified in the Central Region for 59 beds have relinquished their certifications. The remaining seven certified providers are either inactive or are in the preliminary stages of facility development. On August 9, 2002, DMH certified Seneca's CTF for 59 beds for the Central Region. Seneca was encouraged to apply to CDSS/CCLD for a license to become operational. As of this date, there has been no official response from Seneca in regards to their status.

Facility Development and Implementation Issues

As of June 1, 2002, the five operating facilities had a total capacity of 130 beds.[1] Sixty-eight of the certified beds in the Bay Area region and 62 of the 113 beds in Los Angeles are operational. No facilities are operating in the Central, Southern or Superior regions. The Southern region may not need all of its beds, due, in part, to a greater availability of acute hospital beds for youth. Los Angeles and the Bay Area could probably use additional beds, and the need for the remaining Regions is unknown because no CTFs exist in these areas. The operational facilities include:

Starlight CTF, **Inc** (408) 284-9000 **Capacity: 36** 455 Silicon Valley Blvd., San Jose, Ca 95138
Vista Del Mar Child & Family Services – Special Care (310) 836-1223 **Capacity: 21** 3200 Motor Avenue, Los Angeles, Ca 90034
San Francisco Community Alternatives Program (Licensee – Seneca Residential & Day Treatment Center) (415) 206-6346 **Capacity: 22** 887 Potrero Ave. L-unit, San Francisco, Ca 94110
Seneca Oak Grove Program (510) 481-1222 **Capacity: 18** 1034 Oak Grove Road, Concord, Ca 94578
Star View Community Treatment Facility (310) 373-4556 **Capacity: 40** 4025 West 226th St., Torrance, Ca 90505

The process of developing and opening CTFs has been extremely difficult and complex. All of the current CTF providers reported that it took a comprehensive, collaborative and concentrated effort on behalf of the Board of Supervisors, county service agencies, community regulatory agencies, law enforcement, emergency service providers and the CTF provider to (1) build or locate a suitable facility, (2) identify and provide extensive facility development funds, (3) secure the necessary permits, clearances and licensing approval, (4) develop emergency response plans and procedures and (5) identify and provide program start-up costs before the programs could begin accepting referrals. Two of the five programs were already operating as Rate Classification Level (RCL) 14 group homes and converted these facilities to CTFs[2]. Santa Clara County purchased and remodeled the facility in their county and conducted an elaborate six-month planning process involving multiple stakeholders. Contra Costa County purchased a former skilled nursing facility and paid for all the renovations, including the construction

[1] Although Seneca San Francisco is certified for 22 beds, they have agreed with the county to limit their current capacity to 14, and will increase to 16 at the end of the current fiscal year.
[2] Seneca, San Francisco, and Starview, Los Angeles, were previously operating as RCL 14 group homes.

costs for a new school building. Vista Del Mar built a new facility with funds donated specifically for the CTF. The remaining seven providers, whose programs are currently certified by DMH, report difficulties finding sites. Providers that have located a facility are having difficulties obtaining the proper fire clearances, building code permits, etc., that must be obtained before the providers may even submit licensing packets to CDSS/CCLD.

The stigma surrounding mental illness contributes to problems establishing CTFs. Facilities serving these youth are often considered an annoyance at best and a threat to the community at worst. In one community, conversion from an RCL 14 group home to a CTF was opposed even though the facility would have greater security for the youth and theoretically greater reassurance for the community. Local communities have traditionally dealt with only two types of secure facilities—medical institutions or correctional facilities. The fact that this is a totally new kind of secure facility, which is neither a hospital nor a correctional facility, means that state and local communities have to struggle with how to fit CTFs into existing facility rules and regulations.

The costs for building a new facility or remodeling an existing facility are extensive. The start-up costs involved with opening and staffing CTFs are also considerable. One county reported one million dollars in start up costs in addition to the costs for the structure. Implementing a CTF requires significant funding, an experienced dedicated provider working with a county that has a strong commitment to having such a facility in their county, close collaboration among counties within a region and a local political climate that is supportive of the endeavor. Counties and providers that do not have these resources are not able to establish these facilities.

DMH periodically surveys all currently certified providers about their implementation status. The latest survey indicates that one provider, certified for 40 beds, is no longer interested in developing a CTF. The remaining certified providers wish to continue their certifications. The major barriers to implementation are finding appropriate facilities, securing necessary start-up funding and developing the necessary county and community supports.

Funding Structure and Costs

Funding Structure

The funding for CTFs is a combination of funds, involving several agencies and sources. The facility room and board and care and supervision costs are funded as a group home at RCL 14. The decision to include CTFs at RCL 14 was made because this is the highest rate under the current rate setting structure for group homes. CDSS rate setting has historically been based on costs. Since CTFs are an entirely new type of facility, there was no history upon which to justify a new RCL. In addition, creating a unique CTF rate would have required new legislation that would have substantially altered the current system. Under RCL group home funding, Title IV-E funds can be accessed and the funding shared among the federal, state and county governments.

For youth that are federally linked[3], Title IV-E funds pay approximately 50% of the rate. Of the remaining half, the state pays 40%, and the county pays 60%. If there is no federal linkage, the state and county pay the total rate on a 40/60 sharing ratio. Currently, the RCL 14 rate is $6,371 per month per child. CTFs also have other sources of funds through private sources. Additional research is required to determine how CTFs acquire and utilize private funds.

Treatment costs are funded by county mental health programs using the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funding arrangement for Medi-Cal eligible youth, with federal funds reimbursing approximately 50% of the non-hospital Medi-Cal services and State General Funds paying most of the other 50%. Most of the youth placed by social services and juvenile probation are eligible for Medi-Cal funds. Some youth who are placed under Education Code, Chapter 26.5 (mandated mental health treatment for special education youth), are also eligible for Medi-Cal, depending on their parents' eligibility and willingness to apply for Medi-Cal. Chapter 26.5 mental health services are reimbursed to county mental health through the Commission on State Mandates process. For those costs that cannot be billed to Medi-Cal or claimed under Chapter 26.5 through the mandate's claim, reimbursement must come from other mental health revenue sources with limited availability, such as Children's System of Care funding, the Healthy Family Program or realignment funds.

Education costs are paid by the county school district of origin, under their system of reimbursement for Special Education. All of the currently operating facilities have their own non-public schools.

For FY 2001/02, there was an additional supplemental rate included in the State Budget to provide temporary funding to fill the funding gap and encourage implementation of CTFs. A supplemental rate of up to $2,500 per month per child was established. The supplemental rate was intended to supplement, not to supplant, other funding sources. The statutory authority and general guidelines for the CTF supplemental rate process are found in W&I Code, Section 4094.2. Placing counties are responsible for paying 60% of the CTF supplemental rate and the State pays the other 40%. As described in DMH Information Notice No. 01-08,

> "The CTF supplemental rate payable to each facility is determined by calculating the amount necessary to provide each CTF with its maximum state share amount per average child days per month to establish the maximum amount payable. An interim monthly state share is determined using the estimated average number of child days for the month using budget information submitted by the CTF. The final payment amount will be settled annually."

Providers report they have used the supplemental rates to cover the additional costs of care and supervision necessary in this type of facility. County staff and providers interviewed recommended that the supplemental rate be continued and administered

[3]According to the CDSS Eligibility and Assurance Standards Manual, Section 45-202.3.33, a child in a family that meets the standards for the Aid to Families with Dependent Children (AFDC) family group/unemployed program as they existed on July 15, 1996, is considered federally linked and eligible for Title IV-E funding.

through CDSS so that a portion of it could be paid by Title IV-E dollars for federally linked youth.

CTF multiple funding sources are complex and time consuming for the providers to manage, thereby reducing their efficiency and increasing time spent on administrative tasks. Providers must determine which costs belong under each funding category and keep detailed records to delineate all categories and expenses. An elaborate "point" system based on staffing is used to determine the RCL. Medi-Cal costs are limited to the maximum allowances for various types of services such as day treatment, case management and medication support services. Each mental health treatment service must be documented in the client chart in order to allow the county mental health department to claim federal and state Medi-Cal dollars. The CTF must also document the costs of providing the services. Each county mental health department has different timelines and different requirements for documentation, so CTF providers serving more than one county often have to create county-specific formats for reporting. More discussion of documentation requirements will be presented later in this report.

Operating Costs

On-going operating costs are not identifiable at the present time because most of the facilities have been in operation less than a full year and costs have not been settled yet. In addition, FY 2000/01 expenses included start-up costs for virtually all of the CTFs. The chart below depicts current information as reported by the five operating CTFs.

CTF Fiscal Information – FY 2001/02

Facility	Monthly. Expenses[a]	Monthly Salaries & Ben.	Monthly MH Revenue[b]	Number of beds	Monthly Expense per bed	Monthly MH Rev per bed	Daily Expense per bed	Staff Ratio[c]
Starlight, Santa Clara	$622,000	$399,750	$289,000	36	$17,278	$ 8,028	$576	1:3
Starview, Torrance	$715,000	$455,417	$381,000	40	$17,875	$ 9,525	$596	1:3
Seneca, Concord	$383,884	$201,097	$205,875	18	$21,327	$11,438	$711	1:1.75
Seneca SF	$272,827	$205,187	$156,282	14[d]	$19,488	$11,163	$650	1:1.75
Vista Del Mar	$304,049	$214,583	$ 78,675	21	$14,479	$ 3,747	$483	1:2
Average of all 5 facilities	**$459,552**	**$295,207**	**$222,168**		**$18,089**	**$ 8,780**	**$603**	

a Monthly expenses exclude education funds and costs
b MH Revenues includes Medi-Cal, AB3632, County funding and other MH revenues

c Staff ratio only includes child care staff when youth are not in school, during awake hours

d Capacity will increase to 16 starting 7/1/02

Mental health revenues depend upon on the individual facility's policies and procedures for the provision of services and billing. Some facilities bill primarily day treatment and medication support, while others also bill for case management and mental health services. There is no standard way of accounting for costs between care and supervision, mental health treatment, and education. Facilities differ in the way they account for their costs. The costs of the physical plants vary greatly, depending upon proprietorship of the buildings and what kind of capitalization/lease arrangement each facility has. Once facilities have been operating for a longer period of time, and are operating at full capacity, revenues and expenses will undoubtedly change. Meaningful analysis of financial information in the future would require a more consistent format for reporting all costs. The following are conditions which currently exist:

- As reported, the unaudited costs of care and supervision, and particularly staffing costs, substantially exceed the RCL 14 monthly rate.

  This is due to the higher staff requirements for CTFs, including 24-hour nursing staff and the need for more childcare staff and/or more experienced child care staff to work with this challenging population. On an on-going basis, the care and supervision costs will probably be closer to the RCL 14 rate plus the $2,500 per month supplemental rate, or approximately $8,500 per child per month.

- Treatment costs vary.

  These youth require intensive services. Most of the facilities are providing day treatment services and medication support services, and some providers are also providing additional mental health services and case management. Therapeutic behavioral services (TBS) are provided to youth on an as-needed basis. There is not enough fiscal history to establish the average mental health treatment costs, but providers are reporting that costs range from a low of approximately $3,700 to a high of $11,400 per client per month.

- Costs are influenced by the size of these facilities.

  CTFs are intended to be community based with homelike features not large institutions. Even the largest CTF in California does not achieve economies of scale that are possible in larger facilities. The largest CTF in operation has 40 beds. The two out-of-state facilities with program characteristics similar to CTFs interviewed for this study reported total costs (excluding education) in a range of $6,000 to $7,800 per child per month with bed capacities of 180 and 220 respectively. This, together with lower salary and facility costs in other states, makes any comparison meaningless. Based on the current facilities' reports, total CTF costs (excluding education) are averaging approximately $603 per day or $18,090 per month per child.

Facility Licensing, Certification and Monitoring

As the CTF concept is currently designed, it is a “blended” facility, which is both a group home, falling under the regulatory authority of CDSS, and an intensive mental health treatment program under the auspices of DMH. The two State Departments' areas of responsibility are defined in statute—CDSS licenses the CTF and monitors the physical facility, health and safety issues regarding the residents, and criminal background checks of the employees. DMH certifies the mental health treatment program and oversees all aspects of the residents’ mental health treatment. At times these functions overlap. Both departments are involved in the investigation of critical incidents and complaints. Because CDSS has incorporated CTFs into the existing group home structure, CTFs are required to comply with all group home licensing laws and regulations. The requirements for meeting dual licensing and certification requirements, dual regulations and dual monitoring procedures, even in this collaborative atmosphere, create difficulties for both the departments and the providers. For example, CDSS has a statutory requirement to visit the facility within ten days of the filing of a complaint. CDSS and DMH report they are not sufficiently staffed to fulfill this requirement. This created initial difficulties since the departments are supposed to conduct joint investigations. In this case, CDSS and DMH reached an agreement that, when DMH is unable to go out to the facility in a timely manner, CDSS will go out and forward their results to DMH. The decision to conduct bi-monthly joint visits by the two departments has also been helpful in eliminating some of the potential duplication and confusion. As the facilities stabilize their operations and issues get resolved, both departments foresee moving to annual monitoring. As with all collaborative efforts, both agencies need to continue to be responsive to issues that arise due to these dual requirements.

Clients Served

CTFs were specifically designed for youth with the most severe emotional and behavioral disorders. (The currently operating facilities are serving multi-problem youth with very serious emotional and behavioral disorders.) For the most part, the facilities take all of the youth who are referred to them. These youth are the counties’ most difficult to place young people. These are youth for whom many previous placements have not been successful. Some have been in state hospitals, many have had multiple psychiatric hospitalizations, and some have been in juvenile halls as well as other placements. Most youth have histories of severe behavioral problems such as running from other facilities and putting themselves in harm’s way, assaultive behavior, self-destructive behaviors and/or serious suicide attempts. Most youth have not been successful in the highest-level group homes. Current providers were in general agreement about the kinds of youth CTFs are not designed to handle. These are youth with repeated and/or severe, premeditated assaultive behaviors. Although the facilities are able to handle youth with a high degree of acting out behaviors, a pattern of such premeditated behavior is not manageable in this setting. Also, facilities mentioned the mix of youth in the facility as being one factor in their inability to tolerate such challenging youth. One facility also mentioned the physical size of the youth as a factor. Youth with significant developmental disabilities were not considered appropriate by any of the facilities.

The majority of youth in CTFs are dependents that are referred from the child welfare system. Youth placed under W&I Code, Chapter 26.5 (special education students), represent the next largest group, with the smallest group being those placed by juvenile probation departments. Age ranges are from 12 through 17 at age of admission; average age at admission is between 14 and 15. All of the youth in CTFs have a serious psychiatric diagnosis, and most have multiple diagnoses. A majority of youth have mood disorders, anxiety disorders, or post traumatic stress disorder, often combined with behavioral disorders such as conduct disorders and attention deficit disorders. A smaller number have psychotic disorders such as schizophrenia and schizoaffective disorders. Diagnosis does not give the full picture of these youth. One CTF clinical director stated that for all of these youth, in addition to having complicated diagnoses, "something horrible has happened in their lives." Often they have been physically or sexually abused; many of them have witnessed severe violence—even murders. Many have experienced abandonment or devastating losses; and many were born into households where alcoholism, drug abuse, and/or domestic violence were major problems. Many of the youth have had repeated school failures, some have substance abuse problems and some have experienced homelessness, repeated victimization and/or gang involvement.

Two personal stories of youth are presented below to more accurately depict the complexities of the youth who are being placed in CTFs.

> James
> James is a 14 year old who has been living in a CTF for approximately 10 months. He is a ward of the court who consented to a voluntary placement under W&I Code Section 6552. James was born addicted to cocaine. Both his parents were drug addicts. When he was about 18 months old, his mother was arrested on drug and forgery charges. At that time, Child Protective Services removed James and his siblings from their parents' care due to physical abuse and neglect. Between the ages of 18 months and six years, James lived in several different foster homes. When he was six, he was removed from a foster home due to physical abuse, about which he had to testify in court. He spent time in shelter homes. Just before his seventh birthday he had his first group home placement. In 1995, an attempt was made to place James with an aunt, but that ended when James reported that he was sexually abused by his cousin. Although the allegation was never proven, James ended up in a psychiatric hospital, where he remained for several weeks. Upon discharge from the hospital, James was placed in an RCL 14 group home, the highest level group home available in California prior to the establishment of CTFs. He lasted only three days and was rehospitalized, based on out of control behavior and suicidal threats. Two weeks later he was discharged and placed in another RCL 14 facility. This time he was at the facility for 23 days before he was rehospitalized for attempting to jump out of a moving car. This facility reported that James needed a higher level of care, but none was available. For the next two years James "bounced" from group home to hospital to group home and back, with placements in at least 6 different group homes. At the last one, he assaulted one of the counselors and entered the juvenile justice system. Again, he went through a series of placements, hospitalizations, and arrests before finally being placed in the CTF. All in all, James was placed in at least 15 different group

homes (most of them RCL 14), and had multiple placements in some of these. The longest placement lasted about 13 months, but he was in and out of hospitals and juvenile halls during this period. In the past, James has been given diagnoses of bipolar disorder and intermittent explosive disorder as well as his current diagnosis of post traumatic stress disorder, with a secondary diagnosis of oppositional defiant disorder. Throughout his young life James has been prescribed Risperdal, Thorazine, Haldol, Lithium, and Depakote. At the present time he is not on any psychotropic medication. Since James has been at the CTF, he has had no hospitalizations and has not returned to juvenile hall. For the first six months of his placement he had a very difficult time, requiring frequent restraint and a one-to-one program for a period of time. The staff were not at all certain they could help him, as James displayed the behaviors that previously had made it impossible for him to remain in any of the highest level group home placements. The additional staffing and security of the CTF allowed him to feel safe, and after about six months he "turned a corner." He was restrained only once in the month of March and has not required any restraints since then. He is invested in the program and doing well. He has also reconnected with some previously estranged family members and visits them at their home, accompanied by CTF staff. James still has a long way to go, but his CTF placement is providing him with an opportunity for success.

Deborah

Deborah has had problems since she was very young. Her parents took her to psychiatrists who said the schools needed to do a better job with her. The schools were unable to help her, and she continued to have behavior and learning problems. The parents were often given messages that they were bad parents, contributing to or even causing their daughter's problems. By the time she reached puberty, her parents reported that "everything blew up." She attended very little school in the 7th and 8th grades. By the eighth grade she was placed in a probation class but only lasted for two months. She was sent home from school with school officials reporting that they could not teach her because of her problems. At thirteen she was on the streets in spite of her parents' attempts and willingness to help her. She was raped and abused repeatedly including having men lead her into prostitution. She began to cut herself. The parents visited facilities trying to find one that could and would help her. They were dismayed with their choices because the facilities said they could not handle a child with her behavior problems and some of the facilities did not appear to be clean and well run. She was taken to psychiatric hospitals by the police and eventually hospitalized for over a month. She was violent, refused to speak, had "outrageous behavior" according to hospital staff and could not grasp concepts. She was in seclusion and restraint frequently. Eventually she was given several diagnoses including Asperger's syndrome and bipolar disorder. The parents were considering an out-of-state placement when they heard about a CTF program and visited the program. Here the family reports their first impression was that the place was clean and that they were supported as parents. Deborah is showing steady improvement in that she is not cutting herself, she can maintain eye contact and has begun to participate in the program.

When asked what distinguishes youth referred to CTFs from those in intensive wraparound programs in the community, county representatives cite the need for a secure environment and also, for many youth, the lack of a family with whom to develop service plans.

None of the CTFs have been in operation for a full year; therefore, it is too soon to have any meaningful discharge and length of stay data. Initially, there were some premature discharges from several of the facilities due to difficulties establishing a positive therapeutic milieu and other common start-up problems, as the staffs themselves struggled to provide a safe and secure environment for these youth. Parents, advocates and case managers continue to have some concerns but report that the programs are improving and becoming more successful.

Program Models

Site visits were conducted at all five operating CTFs. The design of each program is unique, based upon the philosophy and experience of the provider. Since this category of residential treatment facility was designed to be something between a hospital and a group home, it is not surprising that some CTFs resemble an acute care program while others are more like a community-based residential care facility. Although all of the programs have worked to develop an interior home-like setting, the secure nature of the facilities and the existence of locks and fences make them seem more like institutions than homes. Some existing facilities are more medical in their approach, blending aspects of a hospital or psychiatric health facility within a group home setting. Others are more of a social model, providing intensive therapeutic milieu services with particular emphasis on the development of peer, staff and community relationships. They embody somewhat different philosophies and are different in some of their treatment approaches and their emergency intervention policies and procedures. The programs include elements to recognize the cultural diversity of their youth such as hiring diverse staff and planning events around special days in all cultures.

Based upon information obtained from county representatives who refer youth to these facilities, provider descriptions, client records and personal observation, both models are inviting and serving youth with similar levels of disturbance, similar diagnoses and similar histories. It is far too early to determine whether one model will produce more successful outcomes than will the other.

Program Policies and Procedures

There are several program policy and procedure issues embodied in the legislation and regulations governing CTFs that have been identified by CTF providers and many other stakeholders as needing revision or clarification in order to make facility costs more reasonable, and facilitate on-going operation of the facilities so that providers may concentrate on serving youth.

Staffing Requirements

The first of these issues is related to staffing regulations regarding the requirement for 24-hour registered nursing (RN) staff. Providers report it is costly and difficult to comply

with this requirement. Nursing salaries are high and the availability of nurses who want to work in this type of setting is low. Providers also report that most nurses do not have the experience of working with youth with serious psychiatric disorders in a community setting. The rationale for including this requirement in the regulations was that a facility that allows seclusion and restraint procedures should have high level professional staff with medical background on duty should the need arise to utilize seclusion and restraint procedures. This requirement is for a higher nursing standard than the staffing requirements for Psychiatric Health Facilities[4], which also use seclusion and restraint and are generally dealing with adults and youth with higher or equally high levels of acuity.

Seclusion and Restraint

Methods for controlling and safeguarding youth when dangerous behaviors occur in these treatment programs include seclusion and restraint as defined in both CDSS group home and DMH regulations. These regulations differ somewhat in their definitions. CDSS regulations pertaining specifically to group homes refer to seclusion as “protective separation” and define a “protective separation room” as "an unlocked room specifically designated and designed for the involuntary separation of a child from other children for a limited period of time for the purpose of protecting the child from injuring or endangering himself, herself, or others." DMH CTF regulations refer to “seclusion” as “the involuntary confinement of a child in a room.” CDSS group home regulations distinguish between “manual” and “mechanical” restraint, defining the former as “the use of hands-on or other physically applied technique to physically limit the freedom of movement of a child." Techniques include, but are not limited to, forced escorts, holding, prone restraints, or other containment techniques, including protective separation. Mechanical restraints are defined as “any physical device or equipment which restricts the movement of the whole or a portion of a child’s body, including, but not limited to, handcuffs, restraining sheets, restraining chairs, leather cuffs and belts or any other similar method.”

While manual restraints are permissible in group homes, the use of mechanical restraints is not. DMH CTF regulations use the term “physical restraint” and do not distinguish between manual and mechanical restraint. “Physical restraint” is defined as “physically controlling the child’s behavior." Physical control includes "restricting movement by positioning staff, restricting motion by holding, the application of mechanical devices, and involuntary placement of a child in a seclusion room or any other room in which they are involuntarily isolated.” DMH regulations further require that “they be used only with a signed order of a physician or licensed psychologist, except in an emergency as defined in Section 1901(K)[5]. In such an emergency a child may be placed in physical restraint at the discretion of a registered nurse. An order shall be received by telephone within sixty (60) minutes of the application of physical restraint, and shall be signed by the prescriber within twenty-four (24) hours” (Title 9, California Code of Regulations (CCR), Section 1929(d)(2)).

[4] A Psychiatric Health Facility (PHF) is a non-hospital inpatient psychiatric facility for clients who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. PHFs are licensed by DMH under the provisions of Title 22, CCR, Division 5, Chapter 9.

[5] “Emergency” means an unforeseen situation that calls for immediate action, without time for full deliberation, to prevent the physical injury of a child or others or extreme property damage, which could result in injury.

Although CDSS and DMH have traditionally used different nomenclature in regards to seclusion and restraint, both departments agree on what constitutes a restraint and what does not. CDSS has incorporated DMH regulation by reference in its licensing requirements as a means of adding consistency to the oversight process.

Currently, four of the five programs in operation use only manual restraint and protective separation within the scope of existing CDSS group home regulations. The remaining facility's policy provides for the use of physical restraint as defined by DMH CTF regulations, including manual and mechanical restraint as well as seclusion.

As previously mentioned the staffing requirement for 24-hour RN staff is based on who can order emergency intervention procedures. Most of the individuals interviewed recommended that seclusion and restraint regulations regarding staffing requirements distinguish between facilities that use mechanical restraints and chemical restraints (emergency medication) and those that do not and that the requirements be changed to allow other qualified and trained staff to order restraint and seclusion.

CTF providers reported a commitment to keep the use of seclusion and restraint to an absolute minimum. The providers report the incidents of seclusion and restraint have been decreasing in all of the facilities that use them. Staff appeared knowledgeable about the issues and risks in utilizing restraint and the need to avoid this intervention whenever possible.

At the present time, facilities are operating under temporary waivers from the California Department of Social Services (CDSS) and are not currently required to report incidents of seclusion or restraint to state authorities unless the occurrence of restraint results in death, injury, unconsciousness or other medical condition. Most of the providers indicated they report these incidents to CDSS anyway.

Medication Policies

The existing facilities have differing philosophies about the use of psychiatric medications. Many of the youth admitted to CTFs are on medication at the time of admission. All facilities have procedures for distribution of psychiatric medications. Although California Code of Regulations at Title 22, Section 77079.13 includes a description of emergency pharmaceutical kits ("e-kits"), current DMH CTF regulations do not specifically address the use of e-kits to provide for the administration of emergency medications following a physician's order.

Documentation Requirements

DMH has sponsored a workgroup of staff, county mental health representatives and group home providers to develop a packet of standardized forms that group homes may use for mental health services provided to children placed in their care. This packet includes standardized clinical assessment and annual assessment update forms, client plans, psychiatric evaluation forms, progress note formats for mental health services, day treatment and medication support services and an Informed Consent for Medication form. Currently, this standardized documentation has received approval from DMH and

is ready to be presented to CMHDA for approval and support. These forms meet the documentation requirements in the contract between DMH and county mental health departments regarding the delivery of Medi-Cal services.

CTF providers and CACFS report that current CTF regulations contain some duplicative and burdensome requirements. Current regulations require that intake reports, admission assessments, monthly review reports and discharge reports be typed. There is general agreement from DMH and CDSS that legibly written or typed reports would be sufficient.

Current regulations require that a new admission assessment report be completed within five calendar days of admission and that it contain a number of specific items. Since many youth entering these facilities may have had another recent assessment, some of this information is repetitious and duplicative. The Standardized Clinical Assessment Form mentioned above specifies that "information can be documented directly by the provider, or relevant reports containing the information may be attached."

Current CTF regulations require that a licensed mental health professional review and initial progress notes every 30 days and also sign and date the required monthly clinical review reports. When providers are also providing and billing for additional mental health services, an additional progress note must be written for each additional mental health service. This decision to be the provider of the additional specialty mental health services is up to the individual CTF provider. Medically necessary services to address the mental health needs of a child/youth residing in a CTF can be provided by other mental health providers. Although providers and CACFS have suggested that the additional documentation and review efforts are duplicative and time-consuming, accurate daily information about these youth's response to treatment is critical. DMH has clarified that while each note does have to be reviewed, it does not have to be individually signed by the reviewer—a single signature or initial indicating all notes have been reviewed is sufficient.

Providers report that conflicting documentation timeline requirements from DMH, CDSS and counties result in their having to duplicate their work to conform to several different timelines for completion and submission of similar documents.

Legal Status and Rights Issues

There are three ways that youth may be legally placed in a CTF:

- Voluntary Admission—Most youth enter the CTFs under W&I Code Section 6552. This statute provides for court wards and dependents to voluntarily consent to admission, provided that the court finds them capable of making such a voluntary decision. Youth who are in CTFs under W&I Code Section 6552 have the right to revoke their consent at any time.
- Conservatorship—Youth can be placed on an involuntary basis only if they are conserved and their conservator consents to the placement.
- Voluntary by Parent(s)—Youth can be placed voluntarily by their parents. If the child is between the ages of 14 and 17 and objects to the placement, the child is entitled to a pre-admission "Roger S." hearing to contest the

placement. The child will then be placed in the CTF only if the hearing finds that the child suffers from a mental disorder, there is a substantial probability that treatment will significantly improve the child's mental disorder, the proposed placement is the least restrictive setting necessary to achieve the purposes of the treatment and there is no suitable alternative.

Youth who are signed in by their parents and youth who are on conservatorships cannot be released from a CTF unless their parent or conservator is in agreement or a Roger S. or conservatorship hearing determines they do not require the CTF level of care. Juvenile wards who are in CTFs on a voluntary basis who have been placed by local juvenile probation authorities often have not completed their detention time, thus if they choose to leave the CTF, they will return to the juvenile hall. The majority of youth placed in CTFs are dependents. Youth voluntarily in CTFs have the right to leave the facility whenever they choose to do so.

There was some initial concern that youth could exit the program if they were there voluntarily and that without the higher level of care, there would be dire consequences. These concerns have been minimized. Although youth do file writs, CTF staff report they have been successful in resolving why the child wants to leave and the writ has been withdrawn.

CDSS oversees the child welfare service agencies which are assigned care and supervison of Dependant Children by the Juvenile Court, but does not have the right to force them to remain in secure treatment institutions against their will. This does not mean, however, that the juvenile court cannot order them placed in a non-treatment facility, such as a group home or foster home. W&I Code, Section 6552 states that:

> "If the minor is accepted as a voluntary patient, the juvenile court may issue an order to the minor and to the person in charge of the hospital, facility or program in which the minor is to be placed that should the minor leave or demand to leave the care or custody thereof prior to the time he is discharged by the superintendent or person in charge, he shall be returned forthwith to the juvenile court for a further dispositional hearing pursuant to the juvenile court law."

While this does not assure that the youth will remain in treatment, it does assure a dispositional hearing and could be used for CTF youth as well as those in group homes.

Risk and Liability Issues

Some of the current issues surrounding CTFs have to do with the need to modify regulations based on the experience of the facilities that are now in operation. CTFs did not exist when the regulations were written. Current experience has identified practice issues that warrant consideration for regulatory changes. Additional issues involved the collaboration between CDSS and DMH in developing a new and unique program. Other than hospitals and PHFs, DMH has not certified children's treatment facilities before. The Community Care Licensing Division (CCLD) of CDSS has extensive experience

licensing and monitoring group home facilities, but has not been involved with licensing and monitoring secure treatment facilities.

Both CDSS and DMH have a responsibility to insure that the facilities themselves and the services provided in them are of the highest quality and to protect the safety and the rights of youth residing in them. Providers have additional risk and liability issues.

Recommendations

The concept of CTFs for youth with serious emotional and behavioral disorders was in development for a number of years. It represents a challenging collaborative effort designed to better serve these youth for whom multiple agencies have responsibilities. The purpose of this study was to examine the fiscal and programmatic issues related to these facilities now that several of them are in operation and to make recommendations regarding the CTF program. The following are recommendations for consideration by DMH:

Regulations and Policy

DMH should convene a workgroup including CDSS, county mental health departments, providers and other stakeholders to develop proposed regulations that are flexible enough to allow for a variety of treatment approaches and rules and regulations that complement and do not duplicate one another.

CTF regulations requiring 24-hour on site "qualified" nursing staff should be reviewed by the DMH Program Compliance Unit and any proposed changes in regulations should be considered in relation to the staffing models for facilities with similar populations and treatment objectives.

CTF regulations regarding staffing requirements relating to the use of emergency seclusion and restraint should be reviewed and considered in relation to the pending outcome of the report by the Senate Committee on Developmental Disabilities and Mental Health about the use of seclusion and restraint which was submitted to the Legislature by March 2003. This report will include findings and recommendations, including recommendations about how to develop best practices and reduce harm to staff and clients which DMH and CDSS should consider in relation to any proposed legislation which would change the requirements for the use of seclusion and restraint in CTFs.

DMH regulations and/or policy for documentation should allow CTFs to use the "standardized group home documents" when they are officially released, with the requirement that they be completed within existing CTF timelines. Current regulations should be revised to include legibly hand written as well as typed reports.

Programs should only be required to do the detailed reporting required in Article 6 of the CCL regulations as modified by AB 2877 (Chapter 93, Statutes of 2000, Authored by Assembly Member Thompson). However, to the extent resources are available DMH should be reviewing the numbers of all incidents, both in the aggregate and for unique

individuals as part of its oversight and monitoring responsibilities as recommended below.

DMH should continue to require that a licensed mental health professional review all progress notes and indicate every 30 days that this has been done.

DMH and CDSS should articulate a “prudent provider” policy that would reflect the partnership among the two state departments and the providers to the effect that the state recognizes the uniqueness of CTFs and the challenges they present. As long as investigations of complaints and unusual incidents find that the provider was following all existing laws, regulations and policies, and acting in the best interests of the child, the provider should be able to count on the support of the state in its actions.

Funding

The report identifies issues pertaining to the funding structure for CTFs. CDSS and DMH acknowledge there are a number of complex factors which continue to require extended analysis to understand the fiscal issues of operating CTFs which may have implications for the funding of all levels of group homes. Once financial and personnel resources become available, both departments should work collaboratively with other stakeholders to develop a strategy to assess these issues and to recommend a long term funding strategy

Oversight and Monitoring

DMH should review the numbers of all incidents of seclusion and restraint, both in the aggregate and for unique individuals. DMH should track these numbers in order to determine if CTFs are being successful in their effort to reduce the numbers of seclusion and restraint incidents.

CTFs should be required to track and report discharges and lengths of stay in their facilities in the required biannual reports that are submitted to DMH Licensing and Certification. DMH should monitor facility trends in both of these areas.

DMH, CDSS and counties should consider seeking research funds to study outcomes for youth served and whether they differ in the existing CTF models.

Placement

Part of the required process for establishing a CTF in a county should include a meeting between county mental health, the provider and representatives from Superior Court, Juvenile Court and local placing agencies, so that all of these entities are familiar with the rules and regulations governing legal status and rights issues of youth placed in CTFs.

Counties that place youth in CTFs should assure that there is coordination among all the agencies involved in the placement, including both the Superior Court, which handles the revocation of voluntary consent, and the Juvenile Court, which is responsible for the placement. At the time of placement, an order should be secured

from the Juvenile Court indicating that should the child wish to leave the CTF, the child must to go back to Juvenile Court for a new dispositional hearing. The Superior Court needs to be aware of such an order in the case of a youth who withdraws voluntary consent, so that the youth will return to Juvenile Court for an alternative placement.

At the time of a voluntary placement of a dependent or ward, the placing agency should secure an order from the Juvenile Court indicating that should the child wish to leave the CTF, the child must go back to Juvenile Court for a new dispositional hearing.

Medication

It is reasonable to provide for the use of emergency medications for youth with severe psychiatric illnesses. DMH should develop a policy/regulation governing the use of emergency pharmaceutical kits to provide for the administration of emergency medications following a physician's order. A critical part of the CTF service should be a fresh look at the medications of youth, particularly when one suspects that they have been added on with each new problem. Medication should be used judiciously by a qualified psychiatrist when needed. The current PHF regulations could be used as a guideline in developing similar policies for CTFs.